

BETTER HEARING QUESTIONNAIRE

Our concern is your hearing, and to better help you we ask that you fill out this questionnaire to describe in what ways your hearing affects you. This information is kept confidential and is made a part of your permanent file.

Thank you for placing your trust in us for all your hearing needs.

Date: _____ **Age:** _____ **Date of Birth:** _____
(MM/DD/YYYY)

Name: _____
(First) (Initial) (Last)

Mailing Address _____
(Street) (City) (ST) (Zip)

Home Phone _____ **Cellular Phone** _____ **EMAIL** _____

Occupation (past/present) _____ **Local Doctor:** _____

How did you hear about us? _____
Name of spouse/friend with you today? _____
What is your primary reason for today's visit? _____

MEDICAL/AUDIOLOGIC HISTORY

YES

NO

- Will this be the first time you've had a hearing test? YES NO
If no, what year were you last tested _____
- Have you ever had ear surgery? YES NO
If yes, when? _____ Which ear? _____ Procedure? _____
- Do you have noises or ringing in your ears? YES NO
- Did you have chronic ear infections as a child or adult? YES NO
- Do you have a family history of hearing loss? YES NO
- Have you been exposed to a lot of noise in your life? YES NO
- Have you had any trauma to the head? YES NO
- Do you have sinus or allergy problems? YES NO
When was your most recent cold, sinus, allergy problem? _____
- Do you have any ear pain or pressure? YES NO
- Do you have dizziness, vertigo, or loss of balance? YES NO
- In which ear do you hear best? circle: left right
- What do you believe caused your hearing problem? _____
- Do you wear hearing aids? YES NO
If yes, circle: left only right only both ears
What year did you buy your hearing aids? _____
Approximately how many hours a day do you wear them? _____
Do you have any problems with your hearing aids? YES NO
If yes, explain: _____
- Why have you decided to have your hearing tested at this time?
 - I feel my hearing is poor and may need to be aided.
 - Family/friends have suggested I have my hearing checked.
 - Other reason/explain: _____

